cannot afford to await culture results, and countercurrent immunoelectrophoresis, although completed in a few minutes, is not widely available. A 15 to 30 percent mortality rate in the civilian population is too high and most likely results from the delay in therapy.

By keeping meningococcal disease in mind when confronted with a febrile patient in a toxic condition, particularly when a skin rash is noted, and instituting early therapy, you can increase the patient's chances for survival.

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Early Diagnostic Esophagoscopy in the Management of Corrosive Burns of the Esophagus

AS EARLY AS WE CAN—it may be 10, 12, 14 or even 24 hours after injury—we do an esophagoscopic study in all cases of possible corrosive burns of the esophagus. It's diagnostic esophagoscopy, because all we want to find out is if the esophagus is burned or if it's not burned. If the esophagus is not burned, a patient will be in hospital for a very short time for the treatment of the burns of the lips and buccal mucosa. If the esophagus is burned, we will continue therapy with antibiotics and steroids. Barium swallows do not help us because there could be severe damage, and the scarring and stricture formation takes usually weeks to occur. So, the mistake has been made to get a barium swallow at say two weeks after injury. The results may look pretty good, yet these patients have difficulty eating. In some of them there may even be aspiration of food and we wonder why they keep having these problems. So, I think diagnostic esophagoscopy is vital to see which patient you have to treat.

—GILBERT S. CAMPBELL, MD, *Little Rock*

Extracted from *Audio-Digest Surgery*, Vol. 24, No. 15, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1577 East Chevy Chase Drive, Glendale, CA 91206.